APPLICATION FOR LIFE INSURANCE – PART I

APPLICANT INFORMATION – PROPOSED INSURED A (REQUIRED SECTION)

1.	Proposed Insured A *(First, Middle, Last)*			2.	Male Female		
3.	Date of Birth (If over age 70, please complete Section D.) *(mm/dd/yy)*	4.	Soc. Sec. No.	5.	Are you a citizen of the United States? Yes No If "No," what country?		
6.	Place of Birth *(State, Country)*	7.	Driver's License # & State				
8.	Home Address *(Street, City, State, ZIP)*						
9.	Occupation/Duties	10.	Employer				
11.	Business Address *(Street, City, State, ZIP)*						
12.	Annual Earned Income $	13.	Annual Unearned Income $	14.			
15.	In the last 5 years have you filed for bankruptcy? **(If "Yes," please complete the Financial Supplement.)** Y N	16.	Primary Phone #	AM PM	17.	Work Phone #	AM PM

COVERAGE INFORMATION *(As available per product)*

18.	Plan of Insurance	19.	Amount of Insurance (Specified Amount, if UL or VUL) $

20.

(i) Death Benefit Option *(Complete for Universal Life and Variable Universal Life Product only – not required for Term or Whole Life.)*

Level	Increase by Cash Value	Increase by Premium	Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test (DBQT) – For IRS purposes, premiums will be tested using the Guideline Premium Test unless

Cash Value Accumulation Test is checked (not available on all products or with all riders).

The DBQT cannot be charged after issue unless the terms of the policy require a change.

21. Save Age? Y N *(If not saving age, policy will be current dated.)*

Additional Benefits and Riders: *(If applicable)*	Waiver of Premium
Supplemental Coverage $	Waiver of Monthly Deductions
Term on Spouse/Other Insured Rider $ *(Please complete Section B – Applicant Information – Proposed Insured B)*	Waiver of Specified Premium $ Children's Term Insurance Rider
Accelerated Benefit Rider	*(Complete Child's Supplement)*

Other Benefits and Riders *(not listed above)*. (Please provide full details: e.g. coverage amounts/percentage/etc.):

BILLING INSTRUCTIONS *(AS AVAILABLE PER PRODUCT)*

23.	Premium Mode: Annual Semi-Annual Quarterly Monthly (EFT) Other			
24.	Modal Planned Premium: $	25.	Lump Sum: $	1035 Exchange
26.	Special Billing: *(check one, if applicable)* New List Bill Existing List Bill Number:			

27.	Source of Premium: *(inheritance, loan, business activity)*	28.	Automatic Premium Loan: Yes No *(Complete for Whole Life Only)*

29.	Premium Notices To: *(check one only.) (Please note we cannot bill to your agent.)*
	Owner in Question Refer to #31. | Owner in Question Refer to #37. | Insured at Business | Insured at Residence | Other *(indicate below)*
30.	Special Instructions:

OWNER INFORMATION *(If left blank, Proposed Insured(s) will be owner)*

31.	Owner Name		
32.	Owner Address		
33.	Relationship to Proposed Insured(s)	34.	Owner Soc. Sec. No. / TIN
35.	Date of Birth/Trust Date	36.	Citizen of (Country)
37.	Owner Name		
38.	Owner Address		
39.	Relationship to Proposed Insured(s)	40.	Owner Soc. Sec. No. / TIN
41.	Date of Birth/Trust Date	42.	Citizen of (Country)
43.	Is this policy being purchases as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? Y N		

BENEFICIARY DESIGNATION *(Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)*

Select Primary (P) or Contingent (C) Beneficiary for each line completed. If Trust, check here.

44. P C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN c. Relationship(s) to Proposed Insured
45. P C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN c. Relationship(s) to Proposed Insured
46. P C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN c. Relationship(s) to Proposed Insured
47. P C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN c. Relationship(s) to Proposed Insured
48.	Special Instructions	

APPLICATION INFORMATION – PROPOSED INSURED A

49.	Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? *(If "Yes," please complete and sign all required replacement forms.)*	Y N

50.	Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)* **If none, check this box:** **Please indicate the Type of coverage: Business (B); Key Person (K); or Personal (P).**

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	1035 Exchange	Type
	$			Y N	Y N	
	$			Y N	Y N	
	$			Y N	Y N	
	$			Y N	Y N	

51.	Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? *(If "Yes," please provide details in the space provided.)*	Y N

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	$		
	$		

52.	What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? $	
53.	Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes," please complete the Premium Financing Supplement.)*	Y N
54.	Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes," provide further information; this includes balloon pilots.)*	Y N

GENERAL RISK INFORMATION – PROPOSED INSURED A

55.	Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? *(If "Yes," an Aviation Supplement is required; this includes balloon pilots.)*	Y N
56.	Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hand gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? *(If "Yes," an Avocation Supplement is required.)*	Y N
57.	Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes," a Foreign Travel or Residence Supplement is required.)*	Y N
58.	In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? *(If "Yes," please indicate what type and dates in the "Details" space provided.)*	Y N
59.	Have you ever been convicted of or are you awaiting trial for a felony? *(If "Yes," please indicate type, date, and city/state of felony and if currently on probation or parole, in the "Details" space provided.)*	Y N
60.	Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes," please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.)*	Y N
61.	Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)*	Y N

Type:	**Date First Used:** ***(month/year)***	**Amount and Frequency:**

(Answer this section only when required.)

62.	Provide full name/address/phone number of personal physician(s) and any other physicians seen within past 5 years.		
	a. Date and reason of last visit:		
	b. Tests performed & treatment received:		
63.	Height: ft. in.	a. Has your weight changed by more than 10 pounds during the past 12 months?	Y N
	Weight: lbs.	b. If "Yes," by how many pounds? lbs. Gain Loss	

64.		Age if Living & Health Status	Diabetes, Cancer, Heart Disease? *(include age of onset)*	Age at Death & Cause
	a. Father			
	b. Mother			
	c. Sibling(s)			

65.	**Details**: *(List details from questions 55-60 answered "Yes" and please specify to which question numbers details pertain.)*

SECTION A – HEALTH SUMMARY

APPLICANT INFORMATION – PROPOSED INSURED A

(Complete if not submitting a Medical Supplement – Part II of Application or to initiate underwriting process.
See Underwriting Guidelines for further details.)

1.	Proposed Insured A *(First, Middle, Last)*	2.	Date of Birth *(mm/dd/yyyy)*

			Yes No
	If you answered "Yes" to any of the following questions, please provide further information in the "Details" space provided.		
			Yes No
3.	Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?		
4.	Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?		
5.	**Have you ever had any indication of, or been treated by a licensed medical professional for:**		
	a.	Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	
	b.	Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	
	c.	Anemia, leukemia, clotting disorder or any other blood disorder?	
	d.	Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	
	e.	Asthma, emphysema, allergies, sleep apnea, turberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	
	f.	Seizures, fainting, dizziness, epilepsy, stroke, paralysis, or other neurologic or brain disorder?	
	g.	Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	
	h.	Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleed, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	
	i.	Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	
	j.	Arthritis, gout, or an disorder of the back, spine, muscles, nerves, bones, joints or skin?	
	k.	Any disorder of the eyes, ears, nose or throat?	
	l.	Any mental or physical disorder or medically or surgically treated condition not listed above?	
6.	Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?		
7.	Do you use alcoholic beverages? *(If "Yes," provide Type, Frequency & Amount.)* Type / Frequency / Amount		
8.	Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?		
9.	In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?		

10.	List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.
11.	**Details**: *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*